Appointment of Representative and Authorization to Release Health Information

GroupHealth®

I designate _____

Print name of representative | Mailing address | Relationship

to act as my representative for purposes of requesting a coverage appeal, payment of a claim, or submission of a complaint on my behalf.

My Name: _____

Mailing Address _____

Phone number _____ Date of Birth: _____ GHC I.D. # _____ (if applicable)

_____

Signature | Print Name | Date

Authorization to Release Health Information for Appeals, Claims, or Complaints

Genetic information is not requested by, used or disclosed by Group Health for underwriting purposes.

- I authorize Group Health to disclose to the representative designated above, information relevant to my complaint, claim, or appeal including, but not limited to, medical records and coverage information.
- I understand I do not have to sign this authorization to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party.
- I understand that I may revoke this authorization at any time by sending a written statement to the mailing address at the bottom of this form. I further understand that if I revoke my authorization, it will not affect any actions already taken by Group Health based on this authorization; and I may no be able to revoke this authorization if the purpose of it was to obtain insurance.
- I understand that once Group Health has disclosed health information, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information.
- This authorization expires _____(date or event). Authorization will expire in 12 months if not specified.

Specific authorization is required to release information pertaining to the health care information listed below. By initialing and describing the information to release, I authorize release of the information pertinent to my appeal, claim or complaint relating to testing, diagnosis or treatment for:

_____ Chemical Dependency _____ _____ Mental Health _____

Initials | Describe/Date Range | Initials | Describe/Date Range

_____ HIV/STD/AIDS _____ _____ Reproductive Care (minors only) _____

Initials | Describe/Date Range | Initials | Describe/Date Range

MINORS – A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

_____

Signature | Date | Relationship

☐ Check if patient is a minor

Keep a copy for your records and submit the original to: Group Health Appeals, P.O. Box 34593, Seattle, WA 98124-1593. Please contact Member Appeals at 1-866-458-5479 if you need a copy of this form.